



1051 Pemberton Hill Rd.
 Suite 202, Apex, NC 27502

www.peakcardiology.com

Tel (919) 363-6060
 Fax (919) 363-6040

REGISTRATION FORM

PATIENT INFORMATION

Today's Date:	Primary Doctor:
---------------	-----------------

Patient Name:		DOB:	
Sex: M / F		SSN:	
Marital Status:	Married	Single	Divorced
Widowed			
Address:			
City:		State:	Zip Code:
Home Phone:		Cell/Other:	
E- Mail Address:			
Occupation:		Employer Name:	
Employer Address:			
Employer Phone:			

INSURANCE INFORMATION

Responsible Party Name:		DOB:	
Address (if different):			
SSN:		Phone No.	
Employer Name:		Phone No.	

Primary Insurance

Insurance Name:		Policy Holder Name/ DOB:	
Group No.		Policy No.	
Effective Date:		Relationship to Patient:	

Secondary Insurance

Insurance Name:		Policy Holder Name/ DOB:	
Group No.		Policy No.	
Effective Date:		Relationship to Patient:	

Emergency Contact

Contact Name/ Relationship:		Phone No.	
-----------------------------	--	-----------	--

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid my insurance. I also authorize Peak Cardiology or insurance company to release any information required to process my claims.

Patient/Guardian Signature:		Date:	
-----------------------------	--	-------	--

Peak Cardiology P.A.
MEDICAL HISTORY FORM

Name: _____ Date: _____

DOB: _____ PCP _____

I consider myself to be in (please circle one) Excellent / Good / Average / Poor Health.

I feel good (please circle one) All / Most / Some / Little / None of the time.

Please list your Pharmacy Name and Number _____

Illnesses/Problems/Symptoms

(Please check one and explain)

	Y	N	Present		Y	N	Present
High Blood Pressure				Stroke or mini stroke (TIA)			
High Cholesterol				Vascular Problems/ Blockages			
Diabetes /High Blood Sugar				Lung or Breathing Problems			
Heart Attack				Coughing or Wheezing			
Heart Rhythm Problems				Thyroid Problem			
Heart Failure				Kidney Problem			
Hospitalized Due to Heart				Bladder Problem			
Chest Pain or Discomfort				Prostate Problem			
Palpitations or Skipped Beats				Frequently/ Night Urination			
Shortness of Breath				Cancer or Tumors			
Heart Murmur				Weight loss or gain			
Leg Swelling				Fever			
Fainting/ Blackouts/ Seizures				Depression or Anxiety			
Heartburn or Acid Reflux				Memory Problems			
Ulcers or Indigestion				Blood Transfusion			
Internal Bleeding							
Liver or Hepatitis							

*Explain the ones you may have checked yes to: _____

*Major Surgeries/ Operations: _____

*OB/GYN: LMP _____ Post Menopausal Y / N No. Pregnancies _____

*Cardiac Complications in the Past: _____

*Are You Scheduled for Surgery? Y / N if so when _____ /why _____

*Do You Smoke? Y / N if so # per day _____ if quit when _____

*Do You Drink? Y / N if so # beer/glasses wine _____ per day /week / month

*Allergies to any Medications Y / N _____

*Allergic to x-ray dye/contrast Y / N **OR** Seafood, shellfish or iodine? Y / N

PLEASE LIST MEDICATIONS AND DOSE:

PEAK CARDIOLOGY, P.A.

RELEASE OF INFORMATION FOR FAMILY

In order to release medical information about yourself to a family member (I.e. spouse, son, daughter or significant other), we must have your permission. If at any time a family member contacts the office requesting medical information this form will be consulted first. If that family members name is not listed your information will be withheld.

I, _____, hereby agree that it is acceptable to release medical information to the following person(s):

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

Special Instructions: _____

CONSENT FOR APPOINTMENT REMINDER CALLS

Please contact me at: _____

You **may** or **may not** leave a voicemail with the appointment day and appointment time on my voicemail.

Signature Date

PEAK CARDIOLOGY, P.A.

Patient Acknowledgment Of Receipt of privacy Notice

Peak Cardiology is required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996 to inform its patients of their rights and duties regarding the privacy of their health information. This information is posted the lobby area and provided to the patients of Peak Cardiology at the time of registration.

I acknowledge that I have received a copy of the notice regarding the use and disclose of my health information.

Signature

Date

Print Name

CANCELLATION POLICY

Peak Cardiology understands that occasionally you will be unable to attend your scheduled appointment. When this happens we ask that you kindly notify our office as early as possible, so that we may open that appointment time to patients who may need immediate care. We request that you provide a 24 hour notice to prevent a missed appointment fee. Please be notified that the following fees will be charged when an appointment is missed without notice.

Missed Appointment for:

Office or Consultation Visit-\$25.00 Fee

Echo (ultrasound)-\$50.00 Fee

Stress Test-\$200.00 Fee (without a 48 hour cancellation notice)

I have read and understand the cancellation policy stated and agree to accept responsibility as described.

Signature

Date

Print Name